Bureau of Health Care Quality & Compliance

PoC accepted 7/28/09 B. Carlson per fax

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN635HOS	A. BUILDING _____ B. WING _____	C 06/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARSON TAHOE REGIONAL MEDICAL CENTE	1600 MEDICAL PARKWAY CARSON CITY, NV 89703

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S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/16/09 and finalized on 6/18/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals Complaint #NV00022266 was substantiated with deficiencies cited. (See Tag 300) On 6/16/09 the findings of the complaint investigation revealed an immediate threat to the health and safety of patients who presented to the Emergency Department with attempts of suicide. At 3:45 PM on 6/16/09, immediate corrective action was implemented by the facility. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000	RECEIVED JUL 17 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA Actions taken: On June 15, 2009, the Patient Safety Officer initiated a Root Cause Analysis process including: contacting department manager, department director, establishing staff involved, contacting involved staff to set up interviews, obtaining and reviewing medical record. The RCA team facilitated by the Patient Safety Officer will complete the RCA process and action plan by July 30, 2009. The Patient Safety Officer has ultimate responsibility for the RCA process and monitoring and compliance of the action plan. Actions completed by the Emergency Department Manager: June 15, 2:23pm: Email to ED nurses and ED physicians: "Please do not leave medication in the room with a patient who is in the ED for and 'overdose'. All medications should be removed from the patient immediately. The patient's belongings should be checked for any weapons, or anything the patient could harm themselves with and remove those items." June 16, 3:34pm: Email to ED Nurses and ED Physicians: "Please review the policy for the 'Care of suicidal and homicidal patients' via the link below. Our policy states we will remove all medication and weapons from these patients and place them in a gown. We need to place their belongings in a bag, label, and bring to the nursing station..." The email also suggested improving the process for disposition of the patient's medications. The Emergency Department manager also posted this in the ED lounge and staff who are to read and initial. The ED manager will monitor for staff acknowledgement as evidenced by staff initials. This topic was discussed as an agenda item on the June 16, ED department staff meeting.	
S 300 SS=J	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the	S 300		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Cathy Brandes TITLE CdO (X6) DATE 7-17-09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 300	Continued From page 1 assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on interview, record review, review of the facility's policies and procedures and current standards of practice the facility failed to protect a suicidal patient from self harm. (Patient #1) Findings include: Patient #1 was admitted to the emergency room on 6/12/09 at 1:20 PM, The patient was brought to the facility by ambulance to be evaluated for an intentional overdose of medications and suicidal ideation. Record review revealed that Patient #1 was transported to the Emergency Department (ED) with his medication bottles. The paramedics documented that they had counted the pills and handed them to ED Nurse #1 who received the patient in the ED. Record review revealed that Patient #1 was evaluated by the ED physician on 6/12/09 at 1:40 PM. The physician documented the patient's diagnoses as: "1. Overdose and 2. Depression with self harm idealization." Nurse #1 was interviewed on 6/18/09 at 12:00 PM, and reported that she had taken the pill bottles to the nurses' station and counted the remaining pills. She reported that she placed them in a small bag and kept them at the nurses' station. She reported that she then handed over	S 300	Record review of the EMS Run Sheet documents "O.D. (unintentional)" and the Emergent Admission Triage documents "unintentional OD" and "denies SI" both documents completed by the ED Nurse MB, who admitted the patient. No evidence found in record that paramedics had counted or handed over medication to nursing. **Action:** The Emergency Department Manager coached the ED Admitting Nurse MB: 1. Coached regarding the Suicide Risk Assessment, and appropriateness of when to do a Suicide Risk Assessment. 2. Coached regarding appropriate hand off and documentation regarding receiving medications from the paramedics. The Emergency Department manager has conducted chart audits for completion of Suicide Risk Assessments and has counseled any RN since June 16 and who has not completed a Suicide Risk Assessment as appropriate. The Emergency Department Manager will continue monitoring and auditing. The Emergency Department Manager is ultimately responsible and based on the data from the audits, will follow the organization policy related to staff disciplinary process until 95% compliance is achieved and maintained. **Action:** Emergency Department Director will agendize for discussion at the August 2009 Emergency Department Medical Staff Committee meeting the importance of physician documentation and the requirement of signature time and date on all documents. The director will be responsible for data collection over the next six months for physician compliance and appropriate action by medical staff for non compliance.	

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S 300	Continued From page 2 the care of Patient #1 to Nurse #11. Nurse #1 reported that she was verbally instructed by the ED physician with respect to the pills to "give them to his mother." Nurse #1 reported that she handed the medications to Certified Nursing Assistant (CNA) #2 and observed her taking them to the room and giving them to the patient's mother. She reported that CNA #2 made an entry in the patient belongings list stating that the medications were with the patient's mother. She reported that the CNA left the room as the ED physician went into the patient's room. Nurse #1 reported that she later overheard a conversation taking place in the ED about the patient's mother having called to alert staff that she had not picked up the patient's medications when she left. She also reported that she saw someone from security sitting outside of the patient's room in the ED. She did not recall the security officer's name. She reported that she had no further contact with the patient or staff about the patient's pills, she had not been responsible for his care at the time the call was received, and she had been assigned to care for other patients at that time. The Security Manager, Safety Officer #10, was interviewed and reported that he had no record that a security officer was called to observe Patient #1. He reported that an officer may have been in the area to observe another patient. The patient's mother was interviewed on 6/16/09 at 1:30 PM. The patient's mother reported that, on 6/12/09, the physician came into the room as CNA #2 was leaving and the CNA handed the physician the bag containing the medications. The patient's mother reported that the physician set the medications on the bedside table on top of the patient's clothing. The patient's mother reported that she left the facility and was driving	S 300	Per interview with the ED tech GP, based on emergency room practice, she inventoried medications, labeled with contents (prescription for 90 Soma, counted 68 Soma / prescription for 45 Xanax, counted 23 Xanax) by taping over the top of the bottles, placed the 2 bottles in a biohazard zip lock bag then secured the zip lock bag and placed with the chart at the nurses station. Later she asked the ED physician what to do with the pills and was told to give to the mom. At which time she went to the room, called the mom from the room and gave her the biohazard bag containing the 2 bottles of medication. **Action:** The Emergency Department Manager: 1. Coached the ED Tech GP regarding appropriate documentation and disposition of medications. The Emergency Department Director: 1. Coached the ED Tech GP regarding knowledge of Care of Suicidal / Homicidal Patient policy and instructed ED Tech to review policy. A Team was formed a team including ED director, ED manager, Patient Safety Officer and Pharmacy managers to develop a process to secure medication. It was determined that the current existing process for securing medications is appropriate for this particular patient type and this process will be implemented for this application.	

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S 300	Continued From page 3 home when she remembered that the medications were on the bedside table and that she had left them there. Review of the patient's mother's telephone records revealed that the call was placed 12 minutes after she left the facility to notify them that she had not taken the medications with her. She reported that she spoke to Case Manager #3 and that she was assured that the Case Manager would notify the appropriate staff of her call and concern that her son may have access to the medications. On 6/18/09 at 12:10 PM, Case manager #3 was interviewed and reported that she had received the call on 6/12/09, at either 4:40 PM or 5:40 PM. She reported that she reported the call to Charge Nurse #4. The Case Manager reported she was very concerned that the medications had been left in the room with a suicidal patient and proceeded to go to the room and look for the medication bottles. She reported that she did not find them and told Charge Nurse #4 again that she was very concerned about Patient #1 having access to the medications. Charge Nurse #4 assured her that he understood her concern and "would deal with it." On 6/18/09 at 1:30 PM, Charge Nurse #4 was interviewed. He reported that he did recall Case Manager #3 telling him that she was concerned, but that he had no recollection of being told that a phone call had come in from the patient's mother concerning the medications having been left at the patient's bedside. He reported that he was very busy, but had reviewed the patient's belonging's list and found an entry that stated the medications had been sent home with the patient's mother. He reported that he was no longer concerned because it was documented that the mother had the medications. He	S 300	During interview with the Patient Safety Officer, the Case Manager, CH stated that she did go to the room and look for the medications, and also checked to see if they had been locked up by registration staff. The case manager further stated she did not find any medications. During Interview with the Patient Safety Officer, the ED nurse, JH, (assigned to patient) stated that she was told by the Case Manager, that the medications were left behind, she searched the room, belongings bag, patted the patient down, and asked the patient where the pills were, she did not find any medications. During interview with the Patient Safety officer, the ED Team Lead RN, KS, stated he was aware that the pills did not make it home with the mother and that he made the nurse caring for the patient aware. Record Review by the Patient Safety Officer: There is no documentation in the record regarding the mother's call or search for the pills. This information was not communicated during the hand off communication when the patient transferred to the Tele unit. **Action** The Emergency Department manager has coached the Case Manager CH, the ED Nurse JH and the ED Team Lead RN KS regarding importance of appropriate documentation and completeness of hand off communication. The Emergency Department manager also verbally counseled the ED Nurse JH regarding appropriate documentation and completeness of hand off communication. Further, the ED Team Lead RD KS will (by July 22) be verbally counseled regarding his responsibility as Team Lead RN to follow through with all concerned.	

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S 300	Continued From page 4 reported that he had no recollection of what time he was notified of the call. When asked if he went to the patient's room or asked the patient about the medications he replied, "I had no further interaction with the staff or patient related to those medications." Record review revealed that on 6/12/09 at 6:50 PM, Patient #1 was admitted to a telemetry bed for observation. Nurse #5 was assigned to care for the patient on the telemetry unit. An assessment by the telemetry nurse was documented at 8:30 PM and noted that the patient was "unresponsive." A rapid response team was called in to help resuscitate the patient. He was then stabilized and sent to the ICU. Nurse #6 was interviewed on 6/18/09 at 1:25 PM. Nurse #6 reported that Patient #1 was brought to the ICU floor by the ICU staff with an endotracheal tube in place, on a ventilator, and in a coma. She reported that the patient was accompanied to the ICU by Nurse #6 and intensive care technician (ICU tech) #7. She reported that she was never told at any point that the patient's medications had been left at the bedside and that they had not been found. Nurse #8 was interviewed on 6/18/09 at 1:25 PM. Nurse #8 reported that she had received a nurse to nurse report to discuss Patient #1's status at the beginning of her shift in the ICU on 6/13/09 at about 7:00 AM. No mention was ever made of the missing medication bottles. Nurse #8 reported that, on 6/13/09 at 5:30 PM, she was confronted by Patient #1's mother regarding why she was not contacted when the patient's condition had changed. She reported that she had gone to the patient's room to discuss the matter of notification when the mother asked her	S 300	The Registration Manager will re-inservice all Registration staff regarding the appropriate registration practices to update information. This includes the requirement for updating all information during registration. Also instruct staff on the proper procedure to "Ask" the patient and/or family for information rather than give the information and ask for acknowledgement or validation. The registration manager will be responsible for completion and documentation of staff inservice by August 15, 2009 and monitoring staff compliance by direct observation of registration staff.	

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S 300	Continued From page 5 "where are his pills?" Nurse #8 had reportedly asked the patient's mother "what pills are you talking about?" Nurse #8 reported that the patient's mother then relayed the account of what had happened the previous day in the ED. She further reported that, while in the patient's room, the patient's mother picked up a plastic belonging's bag, pulled out two empty pill bottles, and showed them to her. Nurse #8 reported that this was the first time that she had heard anything about the missing pills. Nurse #9 was interviewed on 6/18/09 at 1:25 PM. Nurse #9 reported that ICU tech #7 had reported to her, on the morning of 6/13/09, that she had seen one empty pill bottle in the patient's room the night before on 6/12/09. Nurse #9 reported that she had asked ICU tech #7 if she had mentioned seeing the empty pill bottle to anyone or if she had documented it, and the ICU tech responded "no." ICU tech #7 was interviewed on 6/19/09 at 10:34 AM. She reported that she had assisted Patient #1 to the bathroom on 6/12/09 at about 9:00 PM, and noticed an empty pill bottle in the pocket of the sweat pants he was wearing. She reported that she did not tell anyone at that time "because he had become unresponsive and required rapid response immediately as he was leaving the bathroom." Record review revealed that Patient #1 was intubated, was put on a ventilator, and was in a coma. An entry made on 6/13/09 at 8:00 AM, noted that the patient had suffered acute seizures and respiratory failure. An entry made by a neurologist on 6/13/09 at 3:00 PM, noted that the patient had suffered from "status epilepticus."	S 300	Page 6 Action Plan The Emergency Department manager has assigned the Emergency Department and Emergency Department Observation staff SWANK #156-10 SBAR, Improved Staff Communication, to be completed by the staff by August 31 and evidenced by the SWANK completion certificates and compliance monitored by the Emergency Department Manager. All ED nursing staff is assigned Swank modules "Documentation of Legal Issues" #30206-09 and "Good Practices for Documentation" #EMRISKMGT-4. Emergency Department Manager is responsible for staff assignments, and monitor for compliance as evidenced by SWANK certificates of completion.	

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S 300	Continued From page 5 "where are his pills?" Nurse #8 had reportedly asked the patient's mother "what pills are you talking about?" Nurse #8 reported that the patient's mother then relayed the account of what had happened the previous day in the ED. She further reported that, while in the patient's room, the patient's mother picked up a plastic belonging's bag, pulled out two empty pill bottles, and showed them to her. Nurse #8 reported that this was the first time that she had heard anything about the missing pills. Nurse #9 was interviewed on 6/18/09 at 1:25 PM. Nurse #9 reported that ICU tech #7 had reported to her, on the morning of 6/13/09, that she had seen one empty pill bottle in the patient's room the night before on 6/12/09. Nurse #9 reported that she had asked ICU tech #7 if she had mentioned seeing the empty pill bottle to anyone or if she had documented it, and the ICU tech responded "no." ICU tech #7 was interviewed on 6/19/09 at 10:34 AM. She reported that she had assisted Patient #1 to the bathroom on 6/12/09 at about 9:00 PM, and noticed an empty pill bottle in the pocket of the sweat pants he was wearing. She reported that she did not tell anyone at that time "because he had become unresponsive and required rapid response immediately as he was leaving the bathroom." Record review revealed that Patient #1 was intubated, was put on a ventilator, and was in a coma. An entry made on 6/13/09 at 8:00 AM, noted that the patient had suffered acute seizures and respiratory failure. An entry made by a neurologist on 6/13/09 at 3:00 PM, noted that the patient had suffered from "status epilepticus."	S 300	Per Patient Safety Officer Interview with the Patient Sitter AG, Patient Sitter states that she assisted patient to the bathroom, kept the patient in line of sight observation while he was in the bathroom. Nurse and C N A arrived in room to begin admit process. While patient still in bathroom, patient began seizure activity, Nurse, C N A and Sitter assisted patient to bed. Rapid Response team immediately notified and arrived. During this time, the sitter removed patient sweat pants and socks and found a large empty pill bottle in the pants pocket; she did not notice what the label said. She then placed the bottle back into the sweat pants pocket, and placed the sweat pants in the belongings bag, which only contained a tee shirt. She states that she did not document any of this. **ACTION:** Emergency Department manager coached the sitter on her role and responsibilities as sitter, appropriate documentation and hand off communication. The Sitter Supervisor has: 1. Reviewed the sitter job description and responsibilities. 2. Developed a Sitter training class 3. Established Sitter competencies 4. Submitted the training class curriculum for CEU's. The Sitter Supervisor has ultimate responsibility for completing Sitter training by August 14, 2009 as well as monitoring the Sitters and evaluating the program on an annual basis.	

Bureau of Health Care Quality & Compliance

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	NVN635HOS	A. BUILDING _____ B. WING _____	C 06/18/2009

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S 300	Continued From page 6 Record review revealed that Patient #1 was evaluated by a neurologist on 6/13/09. The neurologist made an entry into the patient's medical record at 7:30 PM, that read: "Neurology: Spoke with the mother who said that when she left the ED she was supposed to take pills in pill bottles home. She apparently did not do so. Called the ED later and said she did not. Caretaker (ICU tech #7) said that when he arrived at telemetry. She went through his pants and found an empty large pill bottle (presumably the Soma which according to ED nurse had 68 pills in it) there is no record of what or where pills were from time ED nurses told mother to take them home and arrival to telemetry. If he did take the remainder of the Soma it would explain some of the events that transpired." Review of the facility's policy and procedure revealed the following policy: "Subject: Care of Suicidal/Homicidal Patients in the Emergency Department, dated 3/07: Policy: All patients who are actively suicidal/homicidal or who have expressed suicidal/homicidal ideation will be monitored and protected from self harm while in the emergency department. Purpose: The facility recognizes that patients who have a complaint of major depression/suicidal ideation are at increased risk for harm to self or others. It is the responsibility of all emergency department staff to ensure that these patients remain safe until they are admitted for definitive psychiatric care.	S 300	The Emergency Department Director and Manager reviewed the current Care of Suicidal/Homicidal Patient Policy and determined revisions to the policy would identify other patients who have the potential to be affected. A copy of the revised policy is being submitted with this Plan of Correction. Highlights of the policy revisions include: 1. POLICY: "Patients who are actively suicidal/homicidal or who have expressed *intentional or unintentional* suicidal /homicidal will be monitored and protected from self harm while in the Emergency Department. 2. PURPOSE: "CTRMC recognizes that patients who have a complaint of ~~*major*~~ depression/suicidal ideation are at increased risk from harm to self or other. It is the responsibility of all Emergency Department staff to ensure that these patients remain safe until they are *excluded from* or admitted for definitive psychiatric care. 3. PROCEDURE: "1. A Suicide Risk Assessment" will be completed on all patients admitted to the ED with *intentional or unintentional overdoses* and/or ideation of self harm. 3. Security is notified *as deemed appropriate, related to the patient condition.* ... *Security or a patient sitter will be assigned for continuous patient observation, as deemed appropriate related to patient condition*....	

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S 300	Continued From page 7 Procedure: If a patient has verbalized suicidal/homicidal ideation or has attempted to harm self or others: 3. Security is notified immediately. Patients rounds/observation documentation record is started at that time. The security officer will assist with belongings as needed. 4. All belongings, including weapons, wallets, purses, keys, medications, and clothing will be taken from the patient and placed in the nurses station. A belongings list will be completed at that time with the patiens's as a witness (if applicable). Weapons will be held as valuables in the hospital safe. Patients will be changed into a hospital gown. 5. If the patient will be in the ED for greater than one hour, a sitter will be called in. The sitter will relieve the security officer. Severity 4 Scope 1	S 300	Policy Revisions continued from page 7 of 8 4. All belongings, including weapons, wallets, purses, keys, medications will be taken from the patient and placed in the nurse's station. All medications will be inventoried by the clinical staff of the Emergency Department. *A Chain of Custody form will also be completed. Medication will be placed in a patient medication inventory security bag and sealed. A completed copy of the Chain of Custody form will be placed on the outside of the security bag. The medication bag will be sent to pharmacy on admission, and secured until the time the patient is discharged from the hospital. Medications will be secured at the nursing station until the patient is discharged from the ED.* *5. at the staff's discretion, patients may be changed into a hospital gown..* The policy has been approved and effective July 15, 2009, Emergency Department manager is responsible for communication to Emergency Department staff via department communication book, staff meeting discussion, posting in the department and monitoring as evidenced by staff initials of receiving communication.	

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